City and County of San Francisco **Department of Public Health**

Mitchell H. Katz, MD
Director of Health

May 7, 2004

Via E-Mail
California Department of Health Services
Medi-Cal Redesign Process

Re: City and County of San Francisco Comments on Medi-Cal Redesign

Dear Sir or Madam:

On behalf of the San Francisco Department of Public Health, the San Francisco Department of Human Services, and the San Francisco Department of Aging and Adult Services, I am writing to comment on the State's Medi-Cal redesign process. Based upon our collective knowledge and experience, we submit the following information for your review as you restructure the Medi-Cal program.

I. BENEFITS

A. *Assisted Living*

Assisted living combines housing, personalized supportive services and health care specifically designed for individuals who need the level of care provided in a skilled nursing or intermediate care facility but who could also live safely in the community if they had access to these services in their home. At a minimum, assisted living facilities provide 24-hour awake staff and two to three meals per day in a common dining area. Other typical services include: health-related services, such as help maintaining compliance with medication regimens and care management; assistance with activities of daily living; transportation; social services; activities and recreation; and housekeeping and laundry.

The availability of assisted living will become increasingly important as California's aging population continues to grow. Functional impairment and the need for long-term care and supportive services increase with age. About 14 percent of California's population is aged 60 or older. California's elderly population is expected to grow more than twice as fast as the total population and will increase by 112 percent between 1990 and 2020.

Not only will an assisted living benefit address the need of aging Californians, but it will also be cost-effective for the State. Assisted living enables the aged and disabled to remain in the community and delays or avoids costly nursing home admissions. This would result in significant savings for the State while ensuring that individuals with skilled nursing needs are able to receive their care in the least restrictive setting as required by the *Olmstead* decision.

In 2000, California passed Assembly Bill 499 (Aroner), which required the State Department of Health Services (DHS) to create a Medicaid waiver program to test the efficacy of providing an assisted living benefit to beneficiaries under the Medi-Cal program. Unfortunately, DHS's progress on this has been slow. Despite the law's requirement that an evaluation of the efficacy

of this program be submitted to the Legislature by January 1, 2003, State DHS has not yet submitted its waiver to the federal government for approval. The first enrollees in this pilot project are not expected until the end of 2004 at the earliest.

Twenty-nine states already offer assisted living under the Medicaid program. The evidence from these experiences is clear. Assisted living is a successful, cost-effective combination of affordable housing with services that help people live more stable, productive lives. It will not only save money for California, it will ensure that the aged and disabled in our community have access to the most appropriate and least restrictive level of care necessary to meet their needs.

B. *Drug Medi-Cal Program*

The Drug Medi-Cal program provides substance abuse treatment for Medi-Cal recipients. As was pointed out by the LAO in a report released February 2004 entitled "Remodeling the Drug Medi-Cal program," Drug Medi-Cal provides a patchwork of services with an inconsistent level of support for different modes of treatment and for different treatment populations. San Francisco recommends that the State use the Medi-Cal Redesign process as an opportunity to integrate all of the LAO's recommendations. This report provides ways to provide greater authority and resources for community-based services, contain the fast-growing costs of methadone treatment, and integrate a new and potentially more cost-effective mode of treatment into Drug Medi-Cal.

C. *Chronic Disease Care Model*

Studies have shown that low-income individuals, including Medi-Cal beneficiaries, report poorer health than higher income groups. Not surprisingly providing care for chronic conditions accounts for three-quarters of national health care expenditures. In California, among individuals below 200% of the federal poverty level (FPL), 25 percent report limitations in work or other activities due to physical health. According to CHIS, Californians under 200% of the FPL report the following health problems:

- 10 percent report asthma;
- 7 percent report diabetes; and
- 8 percent report heart disease.

In recent years, in recognition of the increases in chronic conditions among all populations, innovative approaches to dealing with these populations have developed. Specifically, the Chronic Care Model (CCM) was developed and is being applied to various populations, including those on Medi-Cal. According to the California HealthCare Foundation's (CHCF) report "Examining Chronic Care in California's Safety Net" published in July 2003 CCM can be deconstructed into a number of components,

- Links with community resources
- Health care organization
  - Leadership
  - Financing
- Self-management support

  - Traditional patient education
  - Training in goal setting and problem solving
- Decision support
  - Clinical practice guidelines
  - Clinician education
- Delivery system redesign
  - Planned visits
  - Case management
  - Primary care teams
- Clinician information systems
  - Registries
  - Clinician feedback
  - Reminders

Efforts to improve services for individuals with chronic illness are widely proven to reduce health care costs by preventing expensive emergency visits and hospitalizations. In recognition of this, the San Francisco Department of Public Health is beginning to implement an infrastructure that will allow for implementation CCM throughout the system. These efforts include an electronic medical record, a diabetes registry and a chronic care coalition.

San Francisco believes that the Medi-Cal redesign is an opportunity for the State to support the Chronic Care Model and to save money while providing better care. The CHCF report makes a number of policy recommendations that would serve as an excellent guide for implementation of this facet of the Medi-Cal redesign. For the Medi-Cal program, these recommendations include:

- "Pay for Program" in which payers would reimburse for components of the CCM proven to be effective; and
- Assist safety net providers with development and implementation of CCM programs.

II. ELIGIBILITY

It is widely acknowledged that Medi-Cal rules and procedures are unnecessarily complex and unwieldy. The program's complicated and often arcane administrative requirements are implemented using a combination of outmoded, overburdened, and only semi-compatible automation systems; manual processes still dominate critical, high-volume transition points in the eligibility determination and benefits delivery systems. As a result, services to eligible persons are delayed, foregone, or denied; system-wide enhancements are obstructed; and administrative costs soar.

Especially in tough economic times these circumstances present an obvious and attractive target to policymakers who need to cut expenditures and improve government efficiency. San Francisco strongly endorses the effort to streamline the health coverage bureaucracy. A sense of proportion is required, however, to keep expectations realistic and to do the job right.

In San Francisco County, Medi-Cal eligibility operations cost $24 and $26 million per year in state funds. Meanwhile, the San Francisco Department of Public Health (DPH) receives more than ten times that amount in Medi-Cal payments covering health care it provides to families and individuals. Non-DPH pharmacies, clinics, hospitals, and physicians receive additional Medi-Cal reimbursements.

The return of $10 in funded medical services for every dollar spent administering the program indicates that, for all its faults, the Medi-Cal eligibility system provides a relatively stable, substantial, and efficient source of payments for public health care. Redesign of Medi-Cal eligibility processes must therefore be crafted to safeguard that functionality, focusing primarily on what truly does not work while preserving and improving what does.

A. *Simplification*

There is no more popular Medi-Cal reform proposal, and none more called for, than "simplification." Medi-Cal is too complicated. It employs more than 180 aid codes to track funding streams and scope of coverage. It uses eight separate sets of regulations and budget rules just to deliver the same level of coverage to families who exhibit only slight differences in household income and composition. There are hundreds of similar examples of complexity, each of which exacts an administrative cost.

But simplifying isn't simple. Every administrative dollar saved by so-called simplification—eliminating the assets test, for instance—might well produce tens or hundreds of dollars in new benefits or deprive previously eligible persons of coverage. Designing cost neutrality into such reforms would entail regulatory complexities as bad as or worse than the status quo and produce a more arbitrary, less policy-driven health care system.

The new accelerated enrollment and gateway systems demonstrate the unintended consequences a rush towards "simplification" can induce. In concept, the gateway idea is alluring: Children are enrolled in Medi-Cal at the point of service with minimal demands placed on the applicant. After the Medi-Cal record is established, the county follows up and activates ongoing coverage.

What really happens? Instantaneous enrollment does occur, as intended. But does this represent a genuine client benefit and streamlined process? Not in San Francisco. Despite a loss of state outreach dollars, the county already had in place a functional enrollment process at all points of entry now served by accelerated and gateway systems. Thus, the change is adding no new children to the Medi-Cal rolls.

What are being added, however, are duplicate records. Previously, the county took an application, established a Medi-Cal record, and certified eligibility. Now the county completes these tasks but must also track down and reconcile multiple records for the same person in the statewide MEDS database. That process adds ten to thirty minutes processing time per case, an administrative cost the state did not anticipate and does not fund. Records proliferation also compromises MEDS integrity.

Similar divergence between intent and result can be seen in other recent initiatives. Single Point of Entry was supposed to streamline enrollment in the Healthy Families Program, which it does for some applicants—at the cost of delaying Medi-Cal coverage for others. Midyear Status

Reports were supposed to drop from the rolls parents who fail to respond, which occasionally happens—but without producing savings: Lapsed members re-enroll as soon as they are faced with health care costs.

For these reasons the county is wary of generic "simplification" proposals, especially at a time when the state may be tempted to use such initiatives to reduce county administrative funding. Redesign must be based on competent and comprehensive impact analysis and be flexible enough to take into account varying conditions, strengths, and weaknesses in the different counties.

B. *Merging Healthy Families, Medi-Cal, CHDP and AIM*

Medi-Cal, Healthy Families, the Children's' Health and Disability Program (CHDP), Access to Infants and Mothers (AIM), and other programs intersect in complex and sometimes overlapping ways to provide health coverage to California residents under 250 percent of the federal poverty level (FPL). The primary factors involved in eligibility determinations are age and income. While both of these factors change regularly, eligible family members are often shuffled from program to program.

Eligibility is determined on the local level for some programs (Medi-Cal and CHDP) while determinations for the other programs are made on the State level. Health plan enrollment for Medi-Cal is separate from eligibility determinations and made through yet another entity. These various enrollment processes using different governmental entities and contractors adds difficulties to an already complex situation and is costly to maintain. The Single Point of Entry (SPE) enrollment process is a good idea, but creates an awkward situation where SPE applications are sent to the State and first reviewed by MRMIB. Applications are processed by MRMIB if the family is believed to be Healthy Families eligible but returned to the county for processing if the applicant is thought to be Medi-Cal eligible.

When the State Children's Health Insurance Program (SCHIP) was developed on the federal level, states were given the option of expanding Medicaid, developing a new program or a combination of both of these approaches. California chose a combination of approaches, expanding Medi-Cal and developing the Healthy Families program. This added to the already wide variety of programs serving the same basic mission, to provide comprehensive health coverage to low-income Californians. One family at 150 percent of the FPL may a newborn in Medi-Cal and her older sibling in Healthy Families. This is a confusing situation for families and the coordination between the programs is difficult and costly to maintain. The situation has been made more complex by recent changes, including the dismantling of the Certified Application Assistant (CAA) infrastructure (people were once paid fees to help enroll children in Healthy Families) and the CHDP Gateway (meant to enroll children into an insurance program through a CHDP doctor's visit).

San Francisco recommends an administrative merging of the following programs – Medi-Cal for children and adults, Healthy Families, AIM and CHDP. A merger of programs would make publicly funded health coverage more accessible, comprehensive, cost-effective and user-friendly for families, providers and payers. There would not be a change in the eligibility requirements, but an administrative merger of the programs with outreach and enrollment done

on the local level with appropriate funding made available to counties to do the additional work. This would create one responsible entity in each county, the county human services department, which enrolls and reenrolls families in these programs and managed care plans.

Under this structure, Healthy Families and Medi-Cal could remain as separate programs, while CHDP and AIM would be assumed under them. CHDP and AIM could be folded into Medi-Cal. Preventive visits for children not already enrolled in Medi-Cal or Healthy Families (covered under CHDP) could be paid for under a presumptive eligibility arrangement and the Gateway could still be used to enroll all children in the appropriate program. Under this integration, eligibility should be determined annually, as it is for Healthy Families. In San Francisco, instituting more frequent eligibility determinations has not resulted in any cost savings through disenrollments, but has increased administrative costs.

C. *Premium-based Coverage for Share of Cost Beneficiaries*

The movement of share-of-cost Medi-Cal beneficiaries into premium-based coverage would not only improve the health of Medi-Cal share-of-cost beneficiaries, but could also be a cost-saving measure for the State. t. Under the current share of cost system, Medi-Cal beneficiaries have a disincentive to seek routine and preventive care because the cost for these services may not meet their share of cost for the month. As a result, they may not have the benefit of regular access to a primary care physician, which has been shown to improve health care outcomes, reduce emergency department use, decrease rates of preventive hospitalization, and increase patient satisfaction. It is likely that this population delays seeking care until illness or injury forces them to. In the best-case scenario, they may postpone care until they can incur sufficient medical expenses in one month to exceed their share of cost and maximize their Medi-Cal benefits. In the worst-case scenario, they may delay seeking care until their condition has deteriorated to a point where more costly emergency and/or acute care is required.

Premium levels for this population could be scheduled so as to ensure revenue neutrality for the State while still being substantially lower than an individual's share of cost. The price structure would be derived from total expenditures paid on behalf of and by share-of-cost beneficiaries, determined according to appropriate actuarial principles. This strategy would provide a useful option for persons who qualify for a high share-of-cost but live on a fixed income (i.e.: ABD beneficiaries who do not qualify for the Federal Poverty Level programs), and would lend Medi-Cal a marketplace position more like other health coverage plans.

D. *One-E-App*

San Francisco also recommends that the Medi-Cal redesign include financing and supporting county adoption of a simplified multi-level automated application system such as the California Healthcare Foundation's One-E-App. Unlike regulatory approaches to "simplification," One-E-App is a tool that makes health coverage more accessible in a practical manner and provides the opportunity to create a seamless application process for multiple programs, including other forms of health coverage and other assistance.

E. *CalWIN Developers*

The State should also finance and support rigorous contract compliance by CalWIN developers. The multi-county consortium model has no enforcement mechanism to guarantee delivery of a

product that justifies local or state investment in the project to date. Developers have established a pattern of reneging on earlier promises, shifting tasks, responsibilities, and costs to counties, narrowing the application's scope and capabilities, and recycling outdated and obsolescent technology.

F. *Local Control of Marketing, Outreach, and Client Communication Strategies*

An improved Medi-Cal would permit greater local control of marketing, outreach, and client communication strategies. For example, state DHS currently mandates use of language on client correspondence that is literally incorrect in San Francisco County (e.g.: directing potential Medi-Cal applicants to "the county welfare office"). Expressly allowing local entities more flexibility in designing program processes and materials to meet the county's needs would increase service and efficiency at minimal cost. In addition, Medi-Cal should more tightly integrate the Medi-Cal and managed care systems to promote inter-county coverage by managed care plans and ensure timely enrollment of Medi-Cal eligibles into managed care.

III. FINANCING AND COST-SHARING

Administrative cost savings should be pursued and redundancies eliminated from the system before any cost sharing is considered for Medi-Cal recipients. The Kaiser Family Foundation, in their report from March 2003, *Health Insurance Premiums and Cost-Sharing: Findings from the Research on Low-Income Populations* reports that

> "The health services research literature documents that premiums can discourage enrollment of the uninsured in publicly funded health insurance programs, and cost-sharing disproportionately affects low-income people, and reduces the use of beneficial cost-effective services, preventive care and prescription drugs, which can result in worse health outcomes. The research also shows that cost-sharing policies may not result in cost savings for the Medicaid program, but could result in higher costs in other program services, such as hospitalization."

A. *Leveraging Local Dollars to Maximize Federal Financial Participation*

Because Medi-Cal rates are set so low, California is not maximizing federal financial participation in the Medi-Cal program. According to the most recent Medicaid chartbook produced by the Centers for Medicare and Medicaid Services, California has the second lowest average per patient expenditure of all state Medicaid programs.[1] This is primarily due to low fee-for-service reimbursement rates. California's fee-for-service Medi-Cal payments to physicians rank 42nd among the 51 Medicaid programs.[2]

As a result, county governments that operate the public health care systems that comprise the bulk of California's safety net are forced to use local dollars to bridge the growing gap between the cost of providing services and Medi-Cal reimbursement for these services. In many cases, these financial contributions by county governments, which are subdivisions of the State, are not

[1] "A Profile of Medicaid Chartbook 2000," Health Care Financing Administration, Department of Health and Human Services, September 2000.
[2] "Comparing Physician and Dentist Fees Among Medicaid Programs," Prepared for the Medi-Cal Policy Institute by The Lewin Group, June 2001. Figures adjusted for geographic cost factors.

identified as the State's share of expenditures under the Medicaid program and, therefore, are not subject to a federal Medicaid match. As a result, California is losing federal funding it would otherwise be entitled to under the Medicaid program. While we recognize that raising Medi-Cal rates is not feasible at this time, the State should explore ways to maximize local contributions that may be used to draw down federal financial participation to support the safety net health care system in general and Medi-Cal beneficiaries in particular.

B. *Copayments*

There is significant concern in San Francisco about the proposal to institute copayments and premiums in the Medi-Cal programs. While there are undoubtedly ways to save money and administer these programs in ways that lead to greater cost-savings, creating premiums, copayments and tiered benefit plans do not necessarily lead us down this road. In fact, on the county level, the plans put forward by the State regarding cost-sharing will undoubtedly lead to much higher health care costs. Counties will undoubtedly see an increase in the number of uninsured as premiums and copayments make participation in the Medi-Cal program for the lowest income families in one of the most expensive cities in the State impossible to afford. These people will still need health care and will seek it through emergency rooms, often forgoing preventive care and forcing costly and unnecessary hospitalizations. Reducing provider payments (suggested by the State because copayments will supposedly be collected and offset the reduction) will mean that county health providers bring in less money for each service and that fewer providers will accept Medi-Cal, further overburdening the county health system.

C. *Incentive to See High Cost Providers*

Under the current system, Medi-Cal reimburses for certain services provided by certain providers. Health care services under Medi-Cal could be provided appropriately and less expensively if providers were reimbursed for providing services that are within their scopes of practice. For example, the Dental Practice Act ensures that dentists do the vast majority of dental procedures, including routine services that could be done by dental hygienists. Just recently, in January 2003, legislation became effective that allowed dental hygienists to apply sealants on children's teeth without having a dentist look at the teeth first. Medi-Cal regulations pertaining to reimbursable services provided by dental hygienists should be amended to be consistent with this new scope of practice. This would expand access to dental care for Medi-Cal beneficiaries, create incentives for patients to use lower cost providers, and would allow Medi-Cal to provide needed services at more affordable rates. This should not be confined to just the dental field, but all health provider arenas allowing nurse practitioners and other auxiliary providers to expand their scopes of practice.

IV. AGING AND DISABILITY ISSUES

A. *Mandatory Enrollment of ABDs in Managed Care*

San Francisco would be willing to explore the movement of Medi-Cal aged, blind and disabled (ABD) beneficiaries from fee-for-service Medi-Cal into managed care if certain conditions were met. The most critical issue is the SB 1255 program, which provides $500 million per year to public and safety net hospitals based on CMAC payments for inpatient services to ABD patients. Moving ABD into managed care would eliminate this funding, making the financial situation of

public hospitals such as San Francisco General Hospital untenable. Therefore, until and unless SB 1255 funding can be maintained, San Francisco would oppose the movement of ABD Medi-Cal members into managed care.

Assuming that the SB 1255 funding could be maintained, San Francisco would be interested in participating in a dialogue with the State regarding the use of managed care to provide better and more coordinated care to ABD beneficiaries. However, any such move should be carefully considered and slowly implemented to ensure that services are improved, not disrupted, for ABD beneficiaries, and that public and community providers are not harmed.

B. *Multi-Purpose Senior Services Program (MSSP)*

San Francisco recommends that the State expand the population eligible to receive comprehensive case management and other services currently available under the Multi-purpose Senior Services Program (MSSP) waiver to include adults below age 65 who have similar long-term care needs. This option would consolidate service authorization and case management functions locally for improved service coordination and cost control. Although the HCBS benefit would operate under an aggregate cost cap, case managers would manage services within individual spending levels determined according to levels and types of disability. This model would add coverage for other service options already developed in other states that may prevent or delay more costly skilled nursing facility (SNF) admissions and provide less costly SNF discharge options[3]. Specifically, inclusion of a benefit for adult residential care services[4] was motivated by the current lack of access to supportive housing settings for low-income residents.

Access to comprehensive case management is currently limited to a fixed number of county-allocated MSSP slots and is only available to older adults. Assignment of multiple program-based case managers and service coordinators creates duplicative and uncoordinated efforts that may not be cost-effective administratively and/or optimal in terms of overall service plans. Lack of access to affordable, supportive housing options with 24-hour service capacity (either on-call or on-site) to meet both scheduled and unscheduled service needs results in SNF over-reliance. Efforts to discharge long-term residents of skilled nursing facilities are hindered by the lack of affordable, service-enriched housing that can provide on-demand services in a more structured setting. Moving towards a more integrated long-term care system requires the development of more comprehensive information and case management system, as well as experience with local service authorization.

C. *Nursing Facility A/B Waiver Program*

In addition to increasing the number of slots available through the State's existing nursing facility A/B waiver program, additional program enhancements could improve service management and cost-effectiveness for this virtually inaccessible program. Local enrollment and participant targeting procedures should be adopted that include mechanisms for prioritizing

[3] See for example Reinhard & Fahey (2003). "Rebalancing long-term care in New Jersey: From institutional toward home and community based care," www.milbank.org/reports/030314newjersey/030314newjersey

[4] Development and implementation of California's Assisted Living Waiver Pilot Project (ALWPP) in selected counties should not prevent development of a supportive housing benefit. For example, eligible beneficiaries in Florida may be served under a number of Medicaid waiver and state plan optional benefit programs operating in the same counties.

current nursing facility residents who wish to relocate to community settings and whose service needs and preferences can be cost-effectively accommodated. Enhanced case management functions should be developed that include local fiscal management tools, service plan development and authorization, as well as expanded case manager selection options. Service planning procedures should seek to maximize client participation in negotiating service options that will make the most effective use of formal and informal community resources. Cost caps should be adjusted to account for local nursing facility rate differences that take into account local market costs.

Potential clients face significant access barriers with very few participants and an unreported number of individuals on waiting lists at the county level. Current application and enrollment procedures are centralized at the State level and processed on a first-come, first-served basis. New enrollees reportedly receive very limited assistance initiating newly covered services. County-level enrollment and targeting procedures could more effectively identify individuals who could be served through this program or redirected to more appropriate service options. Cost management or service authorization responsibilities are currently handled by California Department of Health Services, In-Home Operations case managers located in either Sacramento or Los Angeles. Locally maintained information about each participant's actual service costs, along with alternative local service and cost data, will help reduce state level responsibility while capitalizing on local case management skills and resources. Individual cost caps are based on Statewide aggregated rates for NF-A and NF-B clients, which effectively creates a more stringent cost neutrality standard for counties where existing Medi-Cal nursing facility rates and actual HCBS service costs are disproportionately higher.

D. *Consumer-Directed Home and Community-Based Service Model*

This recommended option builds on California's existing In-Home Supportive Service (IHSS) program and the federal Independence Plus initiative by developing a more flexible, consumer-directed benefit for a number of beneficiaries who are able to participate. Individual needs-based budgets, service plans and management procedures would resemble those adopted by other Cash and Counseling demonstration states. Covered services would include the full range of home and community-based services currently available through Medi-Cal, as well as others as indicated by the individual's plan of service and negotiated with the assigned service counselor. State demonstrations indicate California could potentially increase the level of federal matching dollars for services that are currently funded entirely by the State.

This approach fits with a Medicaid HCBS option that has considerable federal support and maximizes consumer direction. Current access to certain HCBS services in California is often a function of specific program eligibility, service category, client location, and age, rather than the beneficiary's actual needs and preferences. Evidence from other state demonstrations indicate that participants have lower spending for nursing homes and other Medicaid services over time than traditional agency service recipients[5]. Finally, this program would facilitate the use of federal matching dollars for family provided services.

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[5] See Dale, S., Brown, R., Phillips, B., Schore, J., & Carlson, B. L. (2003). The effects of cash and counseling on personal care services and Medicaid costs in Arkansas. Health Affairs(W3), 566-575. http://content.healthaffairs.org/cgi/reprint/hlthaff.w3.566v1.pdf

Thank you for your efforts to undertake the complex task of redesigning the Medi-Cal program to increase cost-effectiveness while avoiding significant reductions in eligibility or benefits. We appreciate the State's commitment to ensuring community input into this process and are thankful for the opportunity to support and work with the State to improve the Medicaid program in California. Should you have any questions or require additional information about any of the information contained in this letter, please contact Colleen Chawla, Assistant Director of Policy and Planning in my department, at (415) 554-2633.

Sincerely,

Mitchell H. Katz, M.D.
Director of Health

Cc: Bobbie Wunsch, Pacific Health Consulting Group (via e-mail)